COALITION
FOR BIOLOGICAL REALITY

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Submission in response to:
Sexual Orientation & Gender Identity (SOGI) Conversion Practices

The Coalition for Biological Reality – Australia & New Zealand is a grassroots organisation that works to raise awareness around the negative impacts of gender identity ideology on society. We bring together concerned citizens in a bipartisan, secular coalition to challenge gender identity laws, policies and medical guidelines that have the potential to, or have already, undermined the human rights, dignity and freedoms of Australians and New Zealanders.

Our members include:

- Parents of trans children and adolescents with gender dysphoria
- Clinicians and medical doctors
- Lawyers
- Feminists
- Lesbian, gay, bisexual and transgender people
- Academic researchers
- Religious people
- Transwidows – former partners of male to female transwomen
- Podcasters and YouTubers
- Writers, authors and activists
- Lobbyists and political campaigners
- Women in sport
- International supporters and organisations

We are concerned the issues paper conflates gender identity with sexual orientation when these are two very different matters. The proposed changes to Tasmanian law will make it much harder to ethically treat gender dysphoria in those with the condition and is likely to contribute to unnecessary medical transitioning of autistic, gay, lesbian, bisexual and gender non-conforming children in particular.

A recent UK High Court case, *Keira Bell v Tavistock Gender Clinic* found the use of puberty blockers in children to be 'experimental' and that it was unlikely children are able to give informed consent regarding the long term outcomes of such treatment. If the TLRI is to proceed with the issues paper in its current form, ethical psychotherapy for treating gender dysphoria will be criminalised with 'affirmation' being the only option available. This will leave children and adults who seek to come to terms with their natal sex rather than transition in a very difficult position.

Whilst the Coalition supports efforts to address sexual orientation conversion therapy, our submission is focused on removing any mention of gender identity from the proposed law changes.

Question 1
After considering the background and working definition (see [1.3.23] on page 13), in your opinion, what are and are not 'sexual orientation and gender identity conversion practices'?

Conversion therapy that was historically used to 'treat' homosexuality is an entirely separate issue to ethical psychotherapy aimed at assisting a person with gender dysphoria to come to terms with their natal sex. In previous decades, up to 80% of those with childhood onset gender dysphoria would grow out of the condition as they matured. By banning such therapies, those young people will be pushed onto medical pathways towards transition in the form of puberty blockers, cross sex hormones and surgery.

One data set out of the UK showed that an overwhelming 91.5% of girls presenting with gender dysphoria were *not* heterosexual. Many in the LGB community are calling this trend 'transing the gay away.' In this sense, the 'affirmation' model of care is, in itself, a form of conversion therapy for gender non-conforming LGB youth whose dysphoria may be a symptom of internalised homophobia.

Question 2
Should people be allowed to consent to SOGI conversion practices? If so, at what age and under what conditions?

The 2020 UK High Court case of *Keira Bell v Tavistock Gender Clinic* found it was 'doubtful' and 'highly unlikely' that children under 16 are able to give informed consent regarding the administering of puberty blockers, and recommended that children aged 16 and over should have to apply through a court to obtain such treatment. This is consistent with the Australian Family Court case of *Re Imogen* which found that in cases where parents do not consent to puberty blockers for their child, a court must authorise such treatment. Under the affirmation model of care, puberty blockers are the first course of treatment with nearly 100% of those prescribed going on to take cross sex hormones.

Over the last five years there has been a significant increase in the number of teenage girls suddenly presenting with gender dysphoria who have shown no indication of dysphoria prior to reaching adolescence. This is a new cohort of patients not seen in previous decades. Very little research has been undertaken to explain this epidemic but those that have investigated are finding peer contagion to be a significant factor in what has been labelled 'rapid onset gender dysphoria.' Peer contagion would indicate that transgenderism in this cohort is a trend akin to being 'goth' or 'punk' but with devastating consequences such as infertility, male pattern baldness, permanent facial hair and sexual dysfunction. Tasmania must offer more for these girls by way of psychological support rather than simply 'affirmation care.'

Question 3
Have you been involved in or offered, or are you aware of, any forms of SOGI conversion practices in Tasmania? If so, what were the effects on you, or the person exposed to them?

As mentioned in Question 1, we consider the medical transitioning of gender non-conforming young people to be a devastating form of conversion therapy. Many adult gays and lesbians can remember a time in their youth where they wished they had been born the opposite sex. Internalised homophobia is often an unfortunate part of growing up homosexual in a heterosexual world. Today such gender non-conforming children are being medically transitioned through the 'affirmation only' model of care. The law reforms proposed seek to make this practice the only treatment option available, which will fast track children onto puberty blockers, cross sex hormones and surgery.

Intensive psychotherapeutic support should be the first line of treatment rather than irreversible biomedical interventions.

Question 4
Do you think that Tasmanian law should be changed to address SOGI conversion practices? If so, should this be through comprehensive reform, amendment or both (a hybrid)?

With regard to gender identity conversion practices, no laws should be made. There is no evidence that practices used historically to 'treat' homosexuality have been used to treat gender dysphoria. Extensive research, particularly into the ever growing numbers of detransitioners, must be undertaken to determine the best treatment options for children with gender dysphoria. The UK High Court case of *Keira Bell v Tavistock Gender Clinic* described the use of puberty blockers in young people as 'experimental.' Many doctors around the world have raised their concerns regarding this, most notably the Society for Evidence Based Gender Medicine (SEGM) who are 'concerned about the lack of quality evidence for the use of hormonal and surgical interventions as first-line treatment for young people with gender dysphoria.'

Question 5
Should some or all forms of SOGI conversion practices be criminalised in Tasmania? If so, which, if any, should be dealt with as serious (indictable) crimes and which, if any, should be dealt with as less serious (summary) offences?

As the affirmation model of care for gender dysphoria in children and adolescents is considered experimental, this is not the time to be introducing laws that would criminalise other treatment models. Gender identity is not necessarily innate and unchanging, as evidenced by the fact Tasmanian law currently allows for individuals to change their legal gender identity on a yearly basis. There are well known cases and ever growing numbers of detransitioners who regret having undergone medical transition.

Question 6
Should some or all forms of SOGI conversion practices be made civil wrongs in Tasmania? If so, what sort of practices should people be liable for and how should those subject to such practices be compensated?

Allowing children with gender dysphoria the opportunity to work through the underlying causes of their condition and to come to terms with their biological sex should not be considered a civil wrong under Tasmanian law. Again, we point to the ever growing numbers of detransitioners who regret the harm done to their bodies as evidence that the affirmation model of care is in itself a form of conversion therapy. Detransitioners all have similar stories – that they were pushed toward medical transition and were provided inadequate psychological support as a result of the affirmation model.

Question 7
Should any existing Tasmanian laws (besides criminal laws or the Civil Liability Act 2002 (Tas)) be amended to cover SOGI conversion practices? If so, which ones and in what way?

An inquiry into the affirmation model of care is urgently required before any laws are made to criminalise alternative treatments.

Question 8
Are there any other models or approaches that are preferable to, or should complement, changing the law?

In previous decades, the 'watchful waiting' approach was used to treat gender dysphoria in children. Up to 80% of those treated with this method, combined with robust psychological support, would go on to resolve their gender dysphoria and live as their natal sex, without the need for medical intervention. Health professionals must be able to offer this treatment and freely state the very real risks involved in medical transition without the threat of prosecution. There are also people with gender dysphoria who do not wish to transition but instead to live as their natal sex. They deserve access to care that supports them in achieving this. Under the proposed laws no psychologist or psychiatrist would be able to offer such treatment.

Question 9
Are there any other matters that you consider relevant to this Inquiry and would like to raise?

There are different types of gender dysphoria requiring different treatment approaches. Childhood onset gender dysphoria is largely observed in biological males from an early age. Rapid onset gender dysphoria is a new typology not seen in previous decades, affecting teenage girls and linked to social contagion, i.e. influenced by friends and social media. Autogynephilic gender dysphoria is observed in sexually mature biological males and is considered by well known sexologists as an extreme sexual fetish based on being aroused at the thought of oneself as being female. Autohomoerotic gender dysphoria is observed in biological females and consists of wishing to participate in gay male sex and to become a gay man. To criminalise ethical psychotherapy for these wide ranging conditions is unconscionable.

Furthermore, young people who claim a transgender identity often have comorbid mental health issues such as post traumatic stress disorder, autism, borderline personality disorder, depression, anxiety and eating disorders. In the case of rapid onset gender dysphoria, unexplored trauma from sexual abuse/assault may play a part in teenage girls seeking to escape their sexed bodies. In light of this, gender dysphoria may indeed be a symptom of more complex mental health issues rather than a stand alone condition. Criminalising anything other than affirmation care will lead to unnecessary medical transitioning of already traumatised people.

Thank you for the opportunity to make this submission. Please do not hesitate to contact me at biologicalrealityaunz@gmail.com for further information.

Yours sincerely,

Stassja Frei
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